Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee - July 20, 2012

401 S Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Susan Hayes Gordon, Chairperson
Kathy Chan, IMCHC
Eli Pick, Post Acute Innovations
Judy King, M.D.
John Bouman for Andrea Kovach, Shriver Center
Linda Shapiro, ACHN
Renee Poole, IAFP
Jan Grimes, IHHC
Karen Moredock, DCFS

Members Absent
Mary Driscoll, DPH
Edward Pont, ICAAP
John Shlofrock, Barton Mgt.
Glendean Sisk, DHS
Sue Vega, Alivio Medical Center

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Robyn Nardone
Debra Clemons
Sally Becherer
Paul Bennett
Greg Wilson
Lora McCurdy
Lauren Tomko
Jamie Tripp
Andrea Bennett
James Monk

Interested Parties
Craig Alexander, Community Care Alliance
Mary Ellen Baker, MedImmune
Victoria Bigelow, Access to Care
Hillary Bray, ACHN
John Bullard, Amgen
Chris Burnett, IARF
Mary Capetillo, Lilly
Kelly Carter, IPHCA
Geri Clark, DSCC
Laurie Cohen, Civic Federation
Dean Conrad, DHS
Michael Cowell ICHP
Cathy Cumpston, DHS/DMH
Kara Curtis, BCBSIL
Andrew Fairgrieve, HMA
Eric Foster, IADDA
Donna Gerber, BCBSIL
Arvina Goyal
Dean Groth, Pfizer
Sarah Grusin, Shriver Center
Barbara Hay, FHN
Marvin Hazelwood, Consultant

Interested Parties
George Hovanec, Consultant
Michael Hriljac, IPMA
Teresa Hursey, Aetna
Nadeen Israel, Heartland Alliance
Esther Izaguirre, Community Care Alliance
John Jansa, Moline Health
Glen Johnston, GSK
Andy Kane, Kane Consulting
Nicole Kazee, U of I Health Systems
Kristin Keim, Abbott
Mary Kennelly, Shriver Center
Marissa Kirby, IARF
Margaret Kirkegaard, IHC, AHS
Bill Kolen, LAF
Polina Kostylev, Equipped for Equality
Keith Kudla, FHN
Joel Kurzman, NACDS
Mike Lafond, Abbott
Phillip Largent, Consultant
Bridig Leahy, Planned Parenthood
Joy Mahuria, CBDC
Grace Martos, Molina Healthcare
Marvin Hazelwood, consultant
Kevin McFadden, Astra-Zeneca
Susan Melczer, MCHC
Robert Medorse, Aetna
Diane Montañez, Alivio Med Center
Heather O'Donnell, Thresholds
Melissa Picciola, Equipped for Equality
John Peller, Aids Foundation of Chicago
Jay Powell, Amerihealth Mercy
Mary Reis, DCFS
Phyllis Russell, ACMHAI
Ken Ryan, ISMS
Ben Schoen, Meridian Health Plan
Bruce Simon, Consultant
Matt Werner, Consultant
JulieYoungquist, Lawrence Hall Youth Services

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I. Call to Order

Chairperson Susan Gordon called the meeting to order at 10:05 a.m.

II. Introductions

Attendees in Springfield and Chicago introduced themselves.

III. Approval of March 16, 2012 and May 18, 2012 Meeting Minutes

The March and May minutes were approved unanimously for May and with one opposed for March. No revisions were requested.

IV. Director's Report

HFS Director, Julie Hamos began by recognizing the broad diversity of the group. She apologized for the limited room size for the large group attending today and advised that the meeting would be in a larger room next time.

HFS has had a very busy May and June. When we last met the budget had not been passed. Since then, 4 bills were passed as part of the Medicaid package. Those included: the Save Medicaid and Resources Together (SMART) act which had 62 separate spending reductions; the Cook County waiver; the cigarette tax; and the new assessment for hospitals. There were also section 25 changes.

Director Hamos advised that she didn't plan on going through the SMART act as many were already aware of the changes. She thanked staff for the immense amount of work completed in working with the legislature and in developing the painful but necessary set of proposals. In June, staff worked diligently in preparing the rules and state plan amendments. HFS is reporting monthly to the same legislative group. In June, HFS had filed the rules needed with the work shown on our website. By the end of July, HFS will show the legislature that all the state plan amendments needed have been filed. HFS' position is that we can move ahead with the July implementation date before the federal government has a chance to review the state plan amendments. Our new budget depended on a July 1st implementation date for most items. She asked if any questions on that process going forward.

Dr. Judy King asked if the state-plan amendments have been posted and if the director planned to say more about the 62 spending reductions items and to explain them in a little more detail to allow the public to know that these are sound decisions. For example, the department has a 4 drug limit and before it was a 5 drug limit. She wanted to know HFS' assumptions underlying the decision. She asked if HFS is assuming the physicians won't try to get prior authorization or that physicians are prescribing medications that were not indicated.

Director Hamos advised that the department doesn't post state amendments until they're filed. She stated that HFS is not prepared and did not set up time to review the 62 items; however the department did debate them in very great detail. She added that this was a subject of a very serious and difficult negotiation with the legislature and in the end it was the legislators that made the decisions.

The director stated that on the pharmaceuticals issue, HFS started with a process where the legislators said everything is on the table and that all optional services are gone. The pharmaceuticals were an interesting example as they're considered optional. The legislators understood this and it was an instructive moment. We realized that just because the federal government said 45 years ago that pharmaceuticals were optional doesn't make it so. In looking at possible ways to do cost containment as well as utilization containment, most of the changes for optional services were about utilization controls. HFS looked at what other states, Medicare, and the private market are doing. It turned out that other Medicaid programs that had struggled with budget cuts had gone to either a 4 or 5 script limit. Going to a 4 script limit in Illinois was truly a budget move. HFS learned from other states that it's not a bad idea for Medicaid clients to have someone review all their scripts once a year. We know that some of our clients go from ER to ER to pick up a script at each one. We learned from other states that there was reduced ER use when all these drugs were contraindicated and that the client was overusing and not becoming healthier.

The intent is to have an annual review with a prior approval that lasts a year. The 4 script limit is not a hard cap. It's an attempt to get a prescriber to look at the totality of a client's prescriptions and to institute some form of pharmacy therapy management so that pharmacists are more engaged as well. HFS is not implementing this for all clients at once, but starting with high-users defined as persons with 10 or more scripts. There is a system edit so that when a client hits the 10 script cap, somebody is going to look at those scripts.

James Parker, Deputy Director of Operations, stated that the department is phasing in the 10 script per month cap. The utilization review would look at what script might be eliminated and prior approving what may not be eliminated. Long term care facilities are not in the first round phase-in. HFS would work to include everybody eventually and do this at a speed that our capacity allows. We have federal law to comply with regarding how fast we review prior approval requests. The budget assumption was not based on eliminating all prescriptions over 4 but limiting about half of those with an assumption that many people would need and get something over 4 scripts. The department is still considering if at some point above 4 there would be a hard cap above which the department wouldn't pay. Other states have a hard cap and some states have a soft cap up to a certain point say 3 extra drugs and then there's a hard cap. HFS will feel its way to see what the best way is for Illinois.

Theresa Eagleson, HFS Medical Director**,** added to follow-up on Ms. King's request in a more broad way, out on the HFS website that the director mentioned, the department has put every single emergency rule we have filed in reference to these 62 spending reduction items and also put out a link to the provider and client notices that have been sent in relationship to all these budget items. We are trying to keep this all on the same page to easily find. HFS continues to update it as more things go out such as how to get through the prior approval process and help people get through the different processes.

Dr. King responded that in addressing these medication issues, she remembered reading that some of these drugs might not be part of these limits. She added that about a year ago she raised the issue that Illinois doesn't appear to have an open process of drug utilization review and her understanding is that it is a federal requirement for state Medicaid agencies to have a drug use review committee that includes different phases of drug review and aspects of drug utilization. She stated that for almost every state, except Illinois, she could go to their website and find drug utilization review committee minutes. She stated that this is important because it is a process that allows the public to see how these decisions are made. She is concerned that HFS doesn't have that and hasn't been submitting required drug utilization review reports. She'd like to have as an agenda item a discussion about the HFS drug utilization review process and how it plans to meet the federal requirements. She stated that she was told that this was a waived requirement for Illinois but CMS staff told her this is not true.

Director Hamos suggested that this is an agenda item that has been proposed for the future and that the department would need time to think about how to present this. She stated that for the spending reduction items, if others are interested the department could go over a specific item or the 62 items and give an update.

The director stated that HFS is intent on meeting the spending targets because of the other bill she referenced, the Section 25 change. One of the reasons that HFS got into budget trouble, is because of an age-old practice that allowed Medicaid bills from one year to be deferred into the next year. This was allowed under Section 25.

In the 2011 Medicaid reform law, ending the practice of pushing Medicaid bills into the next fiscal year would be phased-out over 10 years. HFS agreed as it's a terrible budget practice and doesn't help the department's vendors. Under the Medicaid package passed this year, the practice is being phased out over only 2 years. This makes a much more precarious state for the Medicaid budget. If we don't meet all of our target reductions, get fully appropriated, and payoff this gigantic backlog of bills ($2 billion), we'll have leftover bills and vendors would have to go to the court of claims to get paid.

Dr. King asked about the plan for a pharmacy to deny dispensing medication needed by a client if they didn't make their co-pay. She noted that HFS did increase co-pays this year. She understands the estimated savings of

implementing an increase in co-pays was going to be about $10 million. Was there an assumption that money is saved by withholding medication if someone doesn't have the co-pay?

Mr. Parker stated that the $10 million saving assumption was based on collecting a co-pay of $1 on generic drugs and not on withholding medication if the recipient didn't make the copayment. HFS will follow the state plan to allow pharmacists to not dispense when allowed under federal law but this provision only applies to adults with countable income over 100% of the Federal Poverty Level (FPL). This is a very small percentage of people that the department covers. The AABD income limit is 100% FPL. FamilyCare adults are covered up to 133% FPL and would be the persons subject to enforcement of the copayments.

Dr. King asked about the status of the transparency website and the data available. Director Hamos advised that the department has had a transparency website for over a year that included enrollment data. The site now also includes claims data by provider.

Someone asked for a quick status summary of the FamilyCare enrollment reduction. Director Hamos stated that the most painful part of the changes from her perspective was being required to cut off all of the FamilyCare members and Illinois Cares Rx members on very short notice. The department did send out notices and did cancel benefits for those no longer income eligible.

It was asked how long it would take for the gradual implementation of the 4 script limit per 30 days for adult community participants allowed. There was discussion regarding a gradual process in starting with a review with 10 or more scripts per 30 days. Dr. Poole and her colleagues were not aware that HFS would be starting at 10 scripts per 30 day period, and she asked how this information is going to be disseminated to the pharmacists and physicians.

Director Hamos advised that HFS would phase this in as quickly as we can manage it with the spending targets. Mr. Parker added that the department doesn't have a specific time table for phase in. It will be governed by HFS' capacity to handle prior approvals. Until the department feels that they have the recipients with 10 scripts under control, they will have a sense of how fast they can move down. HFS has data that tells how many people are affected as the limit is moved down. There are 72,000 persons with more than 10 scripts per 30 day period. This includes both adults in the community and in group care.

Dr. King asked about a provider notice that would change the method of payment for long acting reversible contraceptives like IUDs and implantable devices. She would like to know what factors were considered as it's a best practice for a family planning provider to have all methods on site. She is concerned that adults are not receiving contraceptives devices as they are costly for providers to keep in stock and that the department has created a barrier to access for contraceptives for some women. HFS should assess the impact of this policy change on women's access to these contraceptive devices.

The director responded that the problem was that very expensive IUDs were being stockpiled but not being used. The department could no longer afford to do that. She advised that she as well as many in the room were mindful of the need for access by women to family planning. The department needs to figure out how the payment follows the woman and continues to work on that.

The Future of Care Coordination for seniors and Persons with Disabilities (SPDs)
Director Hamos gave a presentation on the future of care coordination for seniors and persons with disabilities. See the PowerPoint slides at: The Future of Care Coordination for Seniors and Persons with Disabilities (pdf)
Afterward Director Hamos and Mr. Parker took questions.

Q: Eric Foster: When you speak of the 2 requirements, Medical and Long-term Supports and Services (LTSS), are the behavioral health, mental health and substance abuse services being required as part of that medical

package or a valued added option? A parity law was passed last year in Illinois regarding behavioral and mental health being included in equal service amounts to medical services.

A: It is a requirement as a part of service package phase 1 but not 2. It is built into the capitated rates. It is required for the current Integrated Care program service package and will be included in all the future service package medical components. This is part of the service package for CCEs and MCCNs as well.

Q: Diane Montañez: As the department increases managed care and coordinated care in the state, it would be useful to consider standardizing some of the procedures. Right now, we are working with 6 groups that have different web pages and referral forms. It's difficult to keep track of which forms to use for referral and authorization for each group. Could the department look at this aspect of the business?

A: HFS is hesitant to dictate too much to the MCOs in how they operate but has had discussions with them about trying to unify some of the processes and procedures. The 1500 UB issue came into play particularly with substance abuse partners in considering if substance abuse for residential treatment was in or out. We understand that it gets more difficult for providers that have worked with just the DHS system. We have talked to plans to try to synthesis a uniform approach where it doesn't affect their operations.

Q: Christine Burnett: Your PowerPoint lays out a very different future for agencies that have traditionally contracted with the DHS divisions. There's a lot of work going on with the management improvement initiatives committee around contracts with the 5 relevant agencies. She would hate to have a lot of time spent on trying to revise documents that will be obsolete at some point in the near future. How do you envision the transition of providers connecting not with DHS but with MCEs, in particular for the population of persons in the home and community based services (HCBS) waivers?

A: For Medicaid clients and initially for SPD clients, the providers will be contracting directly with the MCEs. There might be other people served by our sister agencies, even non-Medicaid, who still will have a provider base from which to work. The speed with which we go to or ever get to the more rural areas with MCO style managed care isn't in the immediate future.

Q: John Bouman: For the duals, when you say clients have a choice for medical does that mean fee-for-service? For auto-assigned with opt out, is that only if the clients don't choose a primary provider?

A: The federal design of the dual capitation program on the Medicare side is that everybody will be defaulted or auto-assigned to a MCE plan but would have the opportunity to opt out of the plan. They can opt out to a different plan, a regular Medicare advantage plan other than a dual eligible demonstration plan or opt out to Medicare fee-for-service. So even though for their healthcare option, duals opt back to fee-for-service and to some extent that wrap-around for Medicaid, for Long-Term Supports and Services (LTSS), they will still be in a plan if they want those services.

On the Medicaid only side, the HFS proposal is for recipients to be in a MCE plan for medical and LTSS service packages and it will be mandatory. The auto-assignment would be similar to the Integrated Care program with 60 days to choose a plan and 90 days to change to another plan.

Q: Keith Kudla: **1)** in which specific geographic regions will you roll this out? **2)** If a client chooses Medicare fee-for-service for medical, can they pick one of the Innovations projects (CCE or MCCN) for LTSS?

A: 1) The dual enrollment areas are the greater Chicago area composed of Cook County and 5 collar counties, and the 15 county region in central Illinois. The mandatory Medicaid only SPDs are in place in the greater Chicago area and we will eventually move Medicaid only SPDs in the central Illinois area into mandatory managed care. When we expand beyond those two regions for mandatory, there are a few other regions of the state that include Rockford, Quad cities and Metro-east that would be the next likely areas for mandatory

enrollment. It will be a long time before the deep southern region of Illinois will be considered for mandatory managed care. For this area, an enhanced Primary Care Case Management (PCCM) model makes more sense. In the future, the MCE plans in the mandatory areas would be free to move into the non mandatory areas for voluntary enrollments.

2) If a dual-eligible person in the greater Chicago area opts out of the Medicare part of the dual demonstration, they could go to a CCE to coordinate all of their services. They could also go to a MCCN but only for LTSS.

Q: Heather O'Donnell: Medicaid only clients will be required to enroll. Is this auto-assignment or do the MCEs have to actively enroll people?

A: When the department goes to mandatory enrollment, the client enrollment broker process that is federally required and that HFS used for Integrated Care will continue to be used. Individuals that are mandated will receive an enrollment package explaining the options in their region that may include CCEs as well as other MCEs. They have a 60 day period to make a choice before being auto assigned and then have the 90 day window after auto assignment to make a change to another plan.

Q: Kelly Carter: Is everything we're talking about right now still just the SPD? Has the department switched over any of the FamilyCare or AllKids participants? Is there a plan to include parents and children?

A: HFS hasn't switched over any FamilyCare or AllKids yet but parents and children are part of the plan, as they come later, there will likely be in the same regions and with the 50% managed care enrollment deadline by 2015, some parents and children will need to be included.

Director Hamos added that HFS is actually working on a different deadline as the state also has the Affordable Care Act (ACA). As of January 1, 2014, people will be required to enroll in a MCE and the structure has to be in place to accommodate a much bigger and different population including children and adults before 2015.

Q: Donna Gerber: **1)** With the 20 proposals to serve adults and then their children and families, are we talking about Medicaid only SPD adults in the CCE process? **2)** Under the dual eligible component it says that it will include duals and non-dual Medicaid only. Will the non-dual Medicaid only be auto enrolled in that process?

A: 1) Director Hamos believed that for the CCEs, HFS offered an opportunity to also serve duals in a fee-for-service approach. But again it will be required if people want the long-term supports and services (LTSS). In the Innovations proposal, CCEs and MCCNs would serve SPDs and in addition may also serve an equal amount of parents and children. For example if 1000 SPDs are served, 1000 children and adults may also be served. It is designed to a more holistic approach to serve the population.

2) For the duals solicitation, HFS also included for the companies that prevail that they would also be asked to serve Medicaid only SPDs. HFS thought of that as a process to get to the point to serve that population. The auto enrollment will operate differently downstate than in Chicago. In Chicago, when HFS rolls out the dual-eligible program and the auto assignment, that process will be duals only because in suburban Cook and the collar counties, the non dual Medicaid only are already enrolled in 1of the 2 Integrated Care plans and the department is not ready to mandate enrollment in the city of Chicago for the Medicaid only SPDs at this point. In the central Illinois region, it is likely that the enrollment process will be simultaneous for both duals and the Medicaid only SPDs. They will be slightly different because of the mandatory nature on the Medicaid side.

Q: For the dual eligible only SPD patient, can you choose one MCO for the Medicare services part and a different another MCE (CCE, MCCN or MCO) for the LTSS Medicaid only part?

A: No. The person must choose a plan that provides both parts.

Q: Andrew Fairgrieve: You're saying the Medicaid SPDs in Chicago are not going to be mandatorily enrolled, at least, initially? If not would they be able to choose one of the MCOs?

A: Director Hamos answered that we are working on that. It is a bit of a glitch. We don't know that today but by next meeting we will. What is important and drove us to a policy position is that it requires change on every level. What drove this, in part, is that we have a lawsuit and consent decree for which we are mindful and intend to meet the goals. It involves about 16,000 persons in Cook County that reside in nursing homes. The advocates, their lawyers and clients on the other side said to us that they were hoping to have a care coordinator or case manager who would be there for that person from the beginning and through that process. Somebody who gave them their options, helped assess their needs, develop the level of care and then take it to the next step of developing a transition plan for people to move to the community. When we looked at that kind of continuity of care, we said that is what a managed care entity is supposed to be doing. HFS wants to build this into the Colbert plan and that is why an early rollout of this is important to us. Since our last meeting we learned that the federal government is rethinking the duals project. Initially they wanted to move that for rollout in January. HFS was looking at enrollment for possibly next April. The department is on a timetable so that in the next six months from October to April, we are going to see a lot of activity to implement this policy.

Director Hamos asked that people review the care coordination plan for SPDs and advised that HFS would add an address to the website where persons can submit comments on the HFS plan and would like to hear comments and feedback from participants so we can really make this work. Comments can be sent in on the following website: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ShareComments.aspx

V. Review of Amendment to MAC Bylaws

Chairperson Gordon reviewed that in March the MAC had agreed to look at revising article I of the MAC bylaws to include a vision statement. For the last meeting in May the draft change was included as part of the meeting notice but because the posting didn't meet the time requirement, the review was deferred until the July meeting. There was not a copy of the revised bylaws included with the July meeting notice and HFS staff couldn't provide a copy of the bylaws revision with the May MAC meeting notice.

Chairperson Gordon decided to postpone any further action until a current revision of the amendment be provided to MAC members for review.

VI. Review of Draft Charge for Access Subcommittee

Chairperson Gordon reviewed the draft charge for the Access subcommittee that was included with MAC meeting materials and the language is shown below. There was discussion about the draft language regarding what different types of health care disparities are included, reference to Medicaid law and defining access. John Bouman suggested that in the first paragraph the word regardless be changed to because.

Renee Poole made a motion to accept the proposed draft as presented to the committee with Mr. Bouman's requested change. The motion was seconded and voted upon. With 6 members voting, 5 were in favor of accepting the subcommittee mission statement and 1 member voted against it.

VII. Subcommittee Reports

Long Term Care (LTC) Subcommittee Report
There was no report for this committee.
Public Education Subcommittee Report
Kathy Chan provided the report. The committee last met in June and at that point the budget had past. A large part of the discussion focused on how clients and providers were being notified about the changes as a result of SB-2840.

The committee will be reviewing enrollment data to analyze enrollment trends as a result of the various changes, especially with a focus on children. Members of the subcommittee were concerned that because parents were losing eligibility this could lead to children being inadvertently cutoff or paperwork being lost.

The subcommittee also reviewed materials that the department was drafting and provided comments during and after the meeting. The next meeting is scheduled for August 9, 2012 from 10 a.m. to noon.

Dr. King stated a request and agreement made back in January that a notice be included with notices that go out to the Medicaid insured letting them know that there were ongoing meetings that talk about Medicaid and that their voice is/was important, that we wanted to hear their voice, and they were welcome to participate in meetings. Ms. King was told that the Public Education subcommittee would review the notice language. She would like to know when that is going to happen.

Mr. Parker shared that Jacqui Ellinger is working on that and the department would work to get that letter to the Public Ed committee in time to review.

Dr. King also wanted to share an idea to consider for the MAC or public education meeting whether or not we want to have meetings at other times for a different public. These meeting are pretty much agency people or businesses. Other interested parties who are at work might want to have something to say. She wanted to throw out the idea that the department may want to have a meeting or forum at a different time and location.

Chairperson Gordon suggested that staff could think about that recommendation.

Robyn Nardone asked for clarification when Chairperson Gordon said staff. It sounded like that was a recommendation to the MAC to consider that as an option to meetings.

Chairperson Gordon asked if the public education would want to discuss during committee changing the meeting time and location.

Ms Chan advised that it could be added to the agenda. She added that it is important to have a consumer voice. It sounds like there would be a slightly different focus of the meeting. The Public Ed committee has the word public in name and the committee looks at a lot of notices but she wondered if this goes more to what Dr. King brought up earlier about the SMART act with a presentation by the director and understanding why Medicaid is evolving. She asked Dr King if her understanding was correct or if she was more interested in looking at the notices and getting public input.

Dr. King responded that in general that all these meetings happen at a time that is suited for a certain population. She added that maybe once a year MAC or Public Ed or any other committee out there may to consider a meeting in the community and perhaps in the evening.

Jan Grimes asked if she could be included in the new Access committee. Chairperson Gordon advised that she could be added to the list of persons that have expressed interest in participating.

VIII. Update on Care Coordination Initiatives Discussion of Subcommittees

Chairperson Gordon asked if someone from the department could give an update and that there was interest in particular in the 1115 Waiver demonstration Project in Cook County.

1115 Waiver Demonstration Project

Mr. Parker reported that HFS has had several meetings with the federal CMS. Recently they have gone through a lot of details on provider networks and payment systems. The department is pushing to have it in place in the next couple of months. The general outline is the same as it has been. It is a limited network being organized by Cook County, which has identified space and has begun to hire people. There will be a special

eligibility unit located on Cook County's campus to help people apply. Based on who has been on the calls from the federal level, the proposal is getting a lot of attention and it appears that CMS is as interested in the waiver as is the department in getting it moved forward.

Innovations Project and Dual Medicare/Medicaid Care Integration Financial Model Project

Mr. Parker stated that earlier the group got a sense of what is going on with the other initiatives and he didn't have anything additional to report that wasn't covered during the director's presentation and discussion.

IX. Open to Committee

- Mr. Bouman asked if at the next meeting or soon for some news about Illinois' position on adopting a basic health plan and where that stands.

Chairperson Gordon would like the department to provide an update on this for the next meeting.

- Ms. Chan stated that since the director mentioned that they do want to move Medicaid expansion during the veto session, she asked whether or not the department has exact language, and would like the director or someone from the department to talk about that at the next meeting.

- Ms. Chan has also heard talk about a Medicaid trailer bill to do some technical fixes to SB2840 and asked for any updates on that at the next meeting.

Mr. Parker stated that anything the department knows it would be glad to share. He would predict that the department would have no language on either of those things for the veto session. He added that he has heard that a lot of people are asking for changes to what was passed in the spring but suspects that it will not be decided until during the veto session which if any of those changes will actually take place. He did not think there would be much of an update in September.

- Is there any projected date for a decision on the bid award for the dual-eligibles projects?

Mr. Parker advised that there is no specific date. The goal is for the end of July but more likely it will be the first half of August.

- Dr. King advised that in thinking about the next meeting the MAC may need to reconsider the sunset of the pharmacy subcommittee as HFS is not going to establish a drug utilization review. She advised that she had a call from someone saying that she had not done enough to convince the director not to make certain changes regarding some particular drugs. She believes that members need to hear what the process is and the needs to reconsider that decision.

- Dr. King would like to see at least one topic of the discussion have some sort of clinical focus. There are so many things like the Illinois Healthy Women waiver and the CHIP report that MAC never talks about.

X. Adjournment

The meeting was adjourned at 12:00 p.m. The next meeting is scheduled for September 21, 2012.